lifeline International

Position Statement on Decriminalisation of Suicide

Position Statement 23/1

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Lifeline International Position on the Decriminalisation of Suicide

Lifeline International is a registered charity in Australia. Lifeline International operates as a global civil society organisation whose 27 Members operate more than 200 crisis line centres in more than 23 countries, spanning every region, and across high, middle, and low-income countries:

Argentina	Australia	Brunei Darussalam	Botswana
Canada (2 Members)	China	Fiji	Ghana
Japan	Korea	Malawi	Malaysia (2 Members)
Namibia	Aotearoa-New Zealand	Northern Ireland	Papua New Guinea
Samoa	South Africa	Sri Lanka	Taiwan
	United States of America (2 Members)	Zambia	

Lifeline International's Statement on the Decriminalisation of Suicide

Suicide is a priority public health concern for all countries. Suicide is a global leading cause of death.

No one wants lives lost to suicide nor the tragic impact of a suicide on those who are left behind.

Lifeline International believes in a world where access to quality suicide prevention support is available and its use openly encouraged.

Laws against suicide are barriers to people talking about their suicidal thoughts or seeking help. They foster social stigma towards people who deserve instead our compassion, understanding and help.

Expressions of suicidal thoughts and plans are expressions of suffering and distress which should be met with compassion, understanding and the offer of help.

It is better to name suicidal thoughts and talk about them rather than keep them secret and maintain a silence which creates feelings of shame, withdrawal, and a profound loss of hope.

Suicide is preventable. Dying by suicide is not the only, nor the best, response to the deep pain and despair that a person experiences when contemplating to end their life.

Support in a time of suicidal crisis saves lives. The simple act of an engagement with another person can interrupt the suicidal state and alter the trajectory in a person's life.

Action taken to provide meaningful community support for people experiencing distress and struggling to cope with difficulties in their lives will contribute to suicide prevention.

Access to quality mental health care and psychosocial support will contribute to suicide prevention.

The offer of support must be regarded as a safe and viable alternative to be accepted by those in need. There should be no detrimental consequences for people seeking that help.

Laws against suicide are not effective or compatible with contemporary suicide prevention strategies which encourage government and community action in a coordinated and multi-layered manner.

Global Perspective on Suicide

Deaths by suicide worldwide are now estimated at around 700,000 per annum, according to the report Suicide Worldwide in 2019 – Global Health Estimates. (World Health Organization 2021) This means more than 1,900 deaths per day by suicide.

Suicide is a global leading cause of death. There are more deaths due to suicide than to malaria, HIV/AIDS, breast cancer, war, or homicide. Suicide is the second most common cause of death among young people. Most suicides occur in low- and middle-income countries (77%) and more than half of those who die by suicide are under the age of 50 years. Higher suicide rates occur in African, Southeast Asian and European WHO regions.

Suicide is a public health priority that demands greater action globally and by individual countries. This is summarised in the following statement from the then Director-General of the World Health Organization in the forward to the first global report on suicide (World Health Organization 2014):

> Unfortunately, suicide all too often fails to be prioritised as a major public health problem. Despite an increase in research and knowledge about suicide and its prevention, the taboo and stigma surrounding suicide persist and often people do not seek help or are left alone. And if they do seek help, many health systems and services fail to provide timely and effective help.
>
> Dr Margaret Chan
> Director-General World Health Organization, 2014

It is encouraging that some progress is being made. In the past 20 years, there has been a 36% reduction in suicide deaths worldwide, with the standardised global suicide rate at 9.0 per 100,000 population in 2019, compared to around 14.0 per 100,000 population in 2000.

However, some countries continue to have higher suicide rates and there are concerns of under-reporting of suicide deaths by some countries due to weak data and reporting systems, misattribution of suicide deaths as accidental deaths, and the Criminalisation of suicide in an estimated 45 countries which impairs open and accurate recording of suicides (Mishara and Weisstub 2016).

Targets for a reduction in suicide mortality have been included in the WHO Comprehensive mental health action plan 2013-2030 (World Health Organization 2021):

- **Global target 3.1:** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes, by 2030.
- **Global target 3.2:** The rate of suicide will be reduced by one-third, by 2030. (This target aligns with Sustainable Development Goal 3.)
- **Global target 3.3:** 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters, by 2030. NB: The risk of suicide may be higher for those who have experienced severe or repetitive events (World Health Organization 2022).

Background to Suicide and the Law

Suicide has not always been regarded as an act against the law. In Roman times, suicide was regarded as an understandable reaction to a loss of pride or failure in battle. The Vikings viewed suicide as a noble death. Ancient Greeks, however, were less approving of suicide, but did not seek to apply sanctions (Tait and Carpenter 2016).

The influence of the Christian Church was critical in the move towards Criminalisation of suicide. Suicide was condemned by the Church at the Council of Carthage in 348 AD and St Augustine declared suicide a sin in 354 AD. During the Middle Ages, western law moved to align criminal law with Church law and established suicide as a criminal act with penalties for those who attempted suicide and their families (De Leo, Burgis et al. 2006).

Over the years, further evolution regarding suicide occurred under British law – and accordingly for other countries utilising its system of common law. During the 19th century, court cases established that suicide was less serious than murder and as a result it was re-classified as a misdemeanour. By the early 20th century, in Britain and European countries, there was growing recognition that if a person attempting suicide should be imprisoned, it should be in the interests of their health, not as a punishment. The link to the laws of the Church was broken in 1882 in Britain through the Interments Act which returned the power to determine a Church funeral for a person who died by suicide back to the religious clergy (Neeleman 1996).

Reform towards the Decriminalisation of suicide came forward during the 19th century. There was a growing recognition during this century that criminal law often placed the greatest pressure on the poor, that there were disproportionate punishments to the offences. The 'humaneness' of punishment was considered by Foucault and others who called for the severity of punishment to simply be whatever was necessary to prevent repetition of a crime.

Regarding suicide, the need to punish either the person who was now deceased or the family who were left suffering from the passing of their relative, was questioned (Vandekerckhove 1998).

Changes in thinking towards suicide occurred towards the end of the 19th century through the influence of the social scientist Durkheim who identified the impact of external pressures or societal stressors in a person's life and viewed suicide as a behavioural response to these factors. The psychoanalyst Freud described mental disorders as medical conditions, suggesting mental health behaviours such as suicide should be responded to medically rather than punitively (Behere, Sathyanarayana Rao et al. 2015).

Towards the end of the 19th century, countries began to decriminalise suicide, with initial moves made in Sweden (1864). By the 20th century many western countries had made the shift such as Finland (1910), New Zealand (1961), and Canada (1972). Suicide ceased to be a criminal offence in England and Wales in 1961, following a joint British Medical Association and Magistrates Association report in 1959 that recommended legal powers were not necessary to force those who attempted suicide into care; concerns about the use of criminal law to discourage suicide had been raised earlier, in the case R v Trench (1955): ***"... to say (attempted suicide) is to be regarded as a very serious crime shows an entire lack of proportion."*** (Neeleman 1996) Other countries decriminalised suicide in more recent times, such as Northern Ireland, in 1993, Sri Lanka in1998, India in 2017 and Singapore in 2020. (Lew, Lester et al. 2022) Contrary to the concerns of some, suicide rates in countries that decriminalise suicide have not increased, although the accuracy of reported deaths improves and in Northern Ireland the reported undetermined deaths decreased (Osman, Parnell et al. 2017).

Currently, around 45 countries have laws that make suicide a criminal offence, with about half of these acting under legal frameworks that relate to religious law, such as Islamic Law, or the Canons of Orthodox Christianity. In these countries, suicide attempts may be punishable offences without the need for a specific statute. Where religious law is the basis for Criminalisation of suicide (and suicide attempts) it reflects the 'sentiments of the collectively' to express moral condemnation of an act of self-murder and/or to shame and humiliate those who attempt suicide, and in expressing social condemnation, prevent others from behaving likewise (Mishara and Weisstub 2016).

Many of the remaining countries appear to criminalise suicide due legacy provisions in their criminal codes from the legal frameworks that were established through colonialisation and have not been significantly reviewed since then. For instance, in Africa, several countries maintain laws concerning suicide that relate to penal codes that have been left unchanged in terms of penalties for suicide and suicidal behaviours (Adinkrah 2016).

In recent times, suicidologists and mental health experts worldwide have encouraged Decriminalisation of suicide in those countries that have retained laws and penalties. The International Association for Suicide Prevention (IASP) has adopted a clear stance in support of Decriminalisation of suicide. A policy position issued in 2020 the IASP makes the following statement:

> "The criminalisation of attempted suicide undermines national and international suicide prevention efforts and impedes access among vulnerable individuals and groups to suicide prevention and mental health services. The International Association for Suicide Prevention (IASP) recommends the decriminalisation of attempted suicide on the grounds that this will reduce social stigma, help remove barriers to obtaining adequate mental health care, increase access to emergency medical services, foster suicide prevention activities, improve the well-being of people who are vulnerable to engaging in suicidal behaviours, and contribute to more accurate monitoring of suicidal behaviours." (IASP 2020)

Decriminalisation of suicide is identified in the WHO Action Plan on Mental Health as a 'option' for countries to consider towards more effective suicide prevention. The Live Life Guide that the WHO has released with recommendations on key strategies for suicide prevention specifically mentions Decriminalisation in the section on awareness raising and advocacy, noting calls for legislative reforms are regarded as population level actions that will support the prevention of suicide:

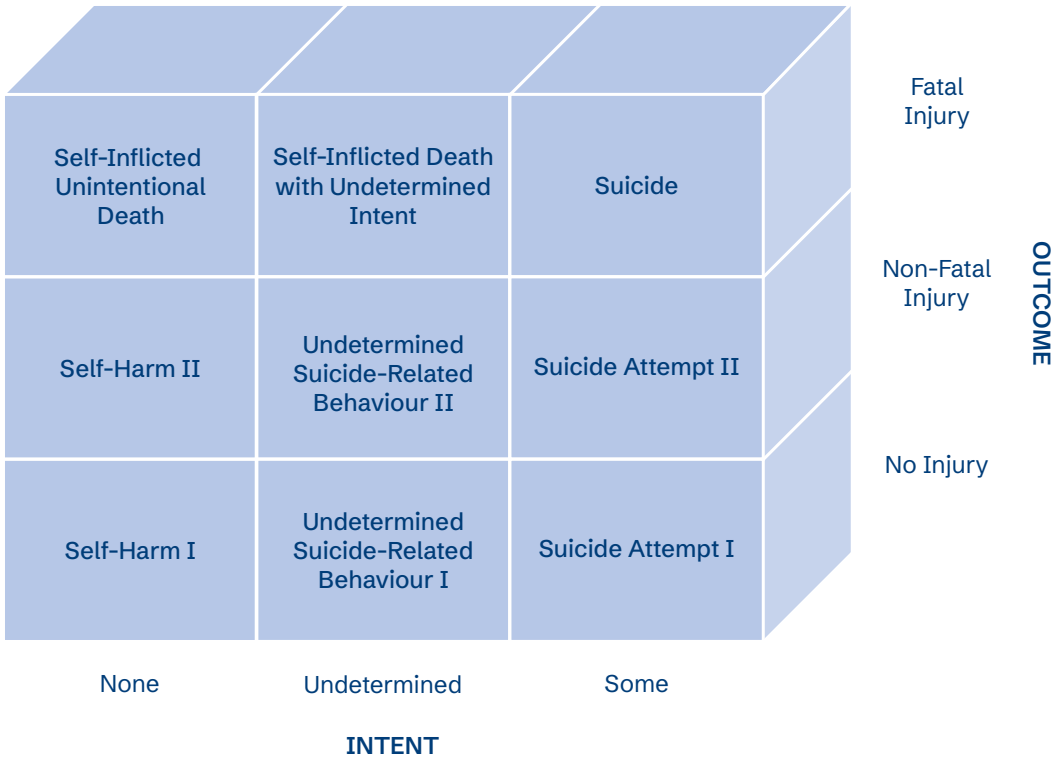
> "Awareness-raising draws people's attention to facts such as suicide is a serious public health issue. Advocacy aims to bring about changes such as Decriminalisation or a national suicide prevention strategy." (World Health Organization 2021)

Suicide Is Not a Crime

Suicide is commonly regarded as the act of killing oneself. In western cultures, the word ‘suicide’ has been reported as a derivative of the Latin words sui (of oneself) and caedere (to kill).

There is more surrounding suicide than the outcome of a lethal act. A person may contemplate suicide well before making an attempt to end their life; a suicide attempt may not result in death.

Recent development of nomenclature based on research, the emergence of theory and a discipline known as suicidology, combined with experiences of those who have survived suicide attempts and the use of psychological autopsy methods to review deaths by suicide, has presented a broader, more complex outlook on suicide. The following schematic presentation of suicide as a multi-layered phenomenon in human behaviour illustrates contemporary knowledge: (Silverman, Berman et al. 2007)



The presence of suicidal thoughts and the development of a desire to die may exist in varying degrees, at varying times, in a person's life. Suicide prevention, accordingly, is most effective if it is directed towards the disruption and diminishing of those thoughts of despair and the desire to die. The following definitions that are used by the International Association for Suicide Prevention (IASP 2020) to indicate layers of complexity surrounding suicide:

- **Suicide:** The act of deliberately killing oneself (World Health Organization 2014).
- **Suicide attempt:** A self-inflicted, potentially injurious behaviour with a non-fatal outcome for which there is evidence (either explicit or implicit) of intent to die (Silverman, Berman et al. 2007).
- **Suicidal behaviour:** A broad term that includes thinking about suicide, planning for suicide, attempting suicide and suicide itself (World Health Organization 2014).

From a legal perspective, the question of intent has featured in considerations of suicidal behaviour. This is reflected in the definition of suicide as recorded in the case R v Cardiff Cit Coroner; Ex parte Thomas [1970] 1 WLR 1475, 1478: which determined that suicide is ***'voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing'*** (Jowett, Carpenter et al. 2018) This suggests intent is always present in considerations of suicidal behaviour.

As shown in the frameworks established by suicidologists to define suicide and suicidal behaviour, the presence of intent is challenged on the basis that it may not be so clearly established. Possibly, a person may be suicidal, in terms of the level of despair they have surrounding their lives, but not necessarily intent on death, even though they may engage in suicidal behaviour. So too, has lethality been questioned as the defining characteristic of suicide. Sometimes a person may exhibit suicidal behaviour without the use of such lethal means as to guarantee their death.

The motives and circumstances surrounding suicidal acts have become better understood as an 'interplay between biological, psychological, social, environmental and cultural factors' (World Health Organization 2014). Moreover, there is now greater recognition that the social and cultural factors may lead to some people and population groups being more vulnerable to suicide because of their circumstances and inequities (Caine 2019).

Accordingly, suicide must be regarded as something beyond the simple notion that a person murders themselves. A simple legal definition of suicide that assumes rationally crafted intent and the use of lethal methods to end one's life does not adequately address contemporary knowledge about the motives, the behaviours, and the outcomes from the suicidal state.

Furthermore, laws that address only the individual's actions may well be overlooking the influence of potentially modifiable factors, including mental health, circumstantial, social, economic, and cultural factors that impact on that individual. To make no allowance for the potential to intervene and prevent suicide seems a profoundly inadequate response to one of the most complex of human experiences.

The Case for Decriminalisation of Suicide

Expert opinion calls for the Decriminalisation of suicide. The Comprehensive Mental Health Action Plan for the WHO refers to Decriminalisation as an optional action for countries within a suite of suicide prevention measures under actions 72, 74 and 76.(World Health Organization 2021) The WHO Report on Suicide notes that Decriminalisation of suicide makes it easier for those with suicidal behaviours to seek help and explicitly suggests countries "should review their legal provisions in relation to suicide to ensure they do not deter people from seeking help."(World Health Organization 2014).

The International Association for Suicide Prevention (IASP) recently strengthened its stance on Decriminalisation with the release of a policy statement as follows:

"IASP considers that the criminalisation of attempted suicide impedes the prevention of suicidal behaviour. The IASP encourages countries where suicide attempts are currently illegal or punishable to develop and implement legislation that decriminalises suicide attempts." (IASP 2020)

A background report authored by leading world experts in suicide prevention, with the support of IASP, has been released to summarise the evidence base that the Criminalisation of suicide does not act as a deterrent; instead it is a barrier to people seeking help regarding mental health and for suicide prevention (United for Mental Health & Thomson Reuters Foundation 2021).

Criminal Laws Do Not Prevent Suicide

Where countries have laws in place that criminalise suicide, there is no evidence to suggest that these laws are effective as a deterrent measure. Legislative measures do not prevent suicides.

A recently published, large multi-nation study of suicide rates and their association with laws that criminalise suicide, over a twenty-year period, has found:

> "Laws penalising suicide were associated with higher national suicide rates." (Wu, Cai et al. 2022).

Moreover, a related publication on the same study found that the reverse was also the case: individual countries that had laws penalising suicide and achieved a decrease in suicide rates did not do so to the same extent as individual countries that did not have these laws and achieved a decrease in suicide rate. That is, ***"average annual percentage in the decrease of suicide was greater for countries in which attempted suicide was not criminalised."*** (Lew, Lester et al. 2022)

This sophisticated, longitudinal study reveals some other important results regarding associations between suicide rates and a country's religiosity, rating on human development index and unemployment rates. In summary, the researchers report that Criminalisation of suicide is more significantly associated with suicide rates in women, compared to men, and that Criminalisation of suicide is more greatly associated with suicide rates in low human development index countries, across both genders. This suggest that, in addition to the ineffectiveness of laws against suicide, their presence fosters gender based and socio-economic inequalities in the occurrence of suicide. For low and middle income countries where disadvantage and inequalities are already impacting negatively on their populations, there seems to be an even stronger case for Decriminalisation of suicide and the introduction of service and supports commensurate with their capacity to do so (Ochuku, Johnson et al. 2022).

Criminal Laws Are a Barrier to Seeking Help

People will not reveal their feelings of despair, ask others for help, or access mental health care, when the law provides for them to be punished for doing so (Milner and De Leo 2010, Behere, Sathyanarayana Rao et al. 2015, Khamis, Panirselvam et al. 2022).

Laws against suicide and suicidal ideation have the effect of reinforcing a social stigma towards those who are, for whatever reason, thinking of suicide. This stigma can fuel a sense of shame and denial for the individual about the feelings and strong urges that they are experiencing, which are themselves generated from an underlying distress. Stigma can extend to the individual's family and impact on family members opportunities for employment, marriage, and participation in community activities. (Adinkrah 2012) Stigma can be long lasting in the social fabric of countries where legislative and judicial frameworks have criminalised suicide, hampering future efforts for suicide prevention through outreach and offers of help. (Spiwak, Elias et al. 2012)

Laws against suicide and suicidal ideation can strongly influence the attitudes of key sources of help such as health professionals and social service workers. Such personnel are careful not to get involved in supporting a person who may be breaking a law. They are less likely to engage with a person in distress and offer help if they fear that the person is contemplating suicide – breaking the law. Attitudes amongst workers that are fear based towards suicide as an unexplained behaviour, or as an afront to moral or spiritual conventions may be reinforced through laws and punitive measures (Hjelmeland, Osafo et al. 2014).

Human Rights Perspectives

The recognition of factors that may impact on the health of a nation's population raises the policy challenge for governments and judicial systems surrounding the rights of individuals within that population to be protected from those factors, because of their right to health, which is described in Article 12 in the International Covenant on Economic Social and Cultural Rights on "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (United Nations 1966). Moreover, the United Nations Human Rights Committee in its General Comment No 36 upholds the right of individuals to be free from acts or omissions that may be expected to cause unnatural or premature death.

> **"... States should take adequate measures, without violating their other Covenant obligations, to prevent suicides, especially among individuals in particularly vulnerable situations." (United Nations 2019)**

It could be argued that where governments have failed to provide supports and services for those individuals who are vulnerable to suicide during a life crisis, or because of the effects of mental illness, they have failed to uphold the right to health and to take adequate measures to prevent suicide. This raises the prospect of suicide prevention being regarded as a human right.

When governments become aware of factors that might act against a person seeking help during times of a suicidal crisis, or experience structural, legal, or systematic barriers to seeking help, this could be regarded as a failure to provide appropriate protections for those who are vulnerable to suicide. Laws, punitive measures, and discriminatory practices against those who express suicidal thoughts or take actions to die by suicide may be seen as barriers that need to be removed if a country is to uphold its obligation to prevent suicide under human rights provisions.

Alternatives to Criminalisation of Suicide

The removal of legal and judicial measures against suicide can encourage people to approach services and community supports for help and to encourage family members and friends who notice signs of distress in a person's communication and demeanour to more readily offer them help.

Crisis Support

The past fifty years has seen advances in knowledge, expertise, and motivation for suicide prevention across the world. Historic understandings of suicidal behaviour and the responses that these have generated now sit against contemporary, evidence-based understandings that demystify what may have been incomprehensible in the past – the reasons and motives for wanting to end one's life. Moreover, the voices of those who have been there, who have survived a suicide attempt or cared for others through a suicidal crisis, are being brought forward. These perspectives reinforce the potential for reaching out, with compassion and understanding, to offer help to the person who has lost hope and feels trapped in their life with nowhere to go. These perspectives prioritise the elimination of stigma and mythology around suicide and the prevention of shaming and rejection towards those who are in suicidal despair. They are people suffering for whom help should be given.

The motivation for suicide was described by Shneidman, an early suicidologist, as a solution to unbearable, internalised, pain, of 'psycheache' (Shneidman 1996). That is, suicide is seen as the only way through problems and pain in life – a constricted form of thinking. This view implies that efforts to relieve a person's pain will also reduce their interest in suicide. More recently, the Integrated Motivational Volitional Theory on Suicidal Behaviour by O'Connor and others, has identified the phenomenon of entrapment as a critical factor – a bridge – for the shift from a sense of distress and defeat that a person may have about living and their enactment of a plan to end their life. (O'Connor and Kirtley 2018) Entrapment is brought about by sense of having few options or supports through which to address the factors generating this distress in a person's life. This outlook implies that action to alleviate the distress brought about by these factors will reduce the sense of entrapment and potentially prevent a suicidal act.

Another development in knowledge about suicidal behaviour has been the concept of a crisis state. In his book titled 'Principles of Preventative Psychiatry' Gerard Caplan described the crisis state as one during which a person's usual capability to cope with life situations before them and intense emotions that they are feeling is severely compromised. They move into a crisis state during which they cannot problem-solve or self-manage their distress levels. A mix of physical, psycho-social and socio-cultural factors may contribute to the crisis state, with the effect being a disabling of coping capabilities and the onset of severe psychological distress. (Caplan 1964) Crisis states may be experienced because of elevated symptoms of mental ill health, such as an anxiety driven panic attack or a psychotic episode. Crisis may also be associated with psychosocial events incidents in a person's life, such as interpersonal relationship conflicts, an inability to provide for basic needs such as food or housing, sudden loss of a loved one, threats to safety and security, violence, and abuse.

Suicidal ideation may develop and escalate during a period of personal crisis as the emotional distress and disruption to normal coping capabilities becomes unbearable. Suicide may become an attractive option, with the person already rendered less able to counter the difficulties in life that they are experiencing. The effectiveness of addressing this crisis state for suicide prevention was demonstrated through the establishment of the Los Angeles Suicide Prevention Centre, with

an telephone crisis line, to provide immediate help for those in crisis (Litman 1965). This service was reported to attract individuals for whom suicidal thoughts had reached an elevated stage (Wold and Litman 1973). The provision of immediate 'emergency telephone therapy' provided an interruption of their suicidal state and an observable reduction in the risk that they may end their lives.

It is the potential to provide immediate crisis support for suicide prevention that has led to the propagation of crisis lines throughout the world, with now more than 1,000 services estimated in many countries.

In a recent review of the literature on the potential of crisis lines and related services, it was reported that: "The majority of studies showed beneficial impact on an immediate and intermediate degree of suicidal urgency, depressive mental states as well as positive feedback from users and counsellors." (Hvidt, Ploug et al. 2016) A more recent review stated: "studies overall provide initial support for such services, particularly in terms of calls impacting immediate proximal and short-term distal outcomes."(Hoffberg, Stearns-Yoder et al. 2019). Research in the past decade has also established the potential for crisis lines to go beyond the call and follow up with the offer of support to those who have contacted them in suicidal crisis (John S. Richardson, Tami L. Mark et al. 2014, Gould, Lake et al. 2018). Studies have also shown that crisis lines can use tools like suicide safety planning to enhance their effectiveness in equipping individuals to stay safe after a crisis (Stanley, Brown et al. 2018). There is considerable opportunity to prevent suicide through the offer of immediate to help to those in crisis.

Public Health Approaches to Suicide Prevention

Public health outlooks on suicide prevention give attention to the contribution of promotion and prevention of health and well-being to effectively reduce the prevalence of suicide in a nation's population (World Health Organization 2012). Contained within these public health strategies for suicide prevention is the removal of factors that may fuel suicidal thoughts and behaviours. In the same way that restrictions on the sale and provision of tobacco products is a public health strategy to reduce detrimental health outcomes associated with tobacco use, restrictions on the access to the means by which suicides can occur has been recognised as an effective strategy to reduce deaths in a given population. The effectiveness of this approach has been demonstrated in countries such as Sri Lanka and India (Utyasheva and Eddleston 2021).

Similarly, there is potential to approach suicide from a broader perspective drawing on public health frameworks to influence the prevalence of known suicide risk factors in the population, while also giving particular attention to those individuals, families and local communities that are exhibiting the signs of distress and struggle that may be related to the development of thoughts and ideas around suicide. It is possible to strengthen individuals and those around them in a planned and targeted way. This has been demonstrated in the evaluation of the US Air Force Suicide Prevention Strategy which found a 33% reduction in suicide risk, alongside a reduction in the risk of severe family/domestic violence (54%), a reduction in the risk of accidental deaths (18%) and a reduction in the risk of homicides (51%). (Knox, Pflanz et al. 2010)

Suicide prevention, therefore, is possible. It is, as Cain describes a 'winnable battle' (Caine 2012). There is sufficient knowledge about the factors that generate suicidal behaviour and their inter-relationships across individual, interpersonal, social and cultural domains; there is sufficient evidence about the potential for crisis intervention to prevent loss of life; there is growing understanding of the benefit of public health perspectives to address emerging factors and strengthen the resources available for individuals to achieve reduction in suicides and suicidal behaviour.

National Suicide Prevention Strategies

There is a growing recognition of the effective use of national suicide prevention strategies through the WHO, IASP and non-government organisations devoted to the cause of suicide prevention . Resources such as the LIVE LIFE guide demonstrate how national strategies can be implemented (World Health Organization 2021). These strategies offer a viable alternative to the use of laws or punishments as mechanisms for suicide prevention.

It is worth noting that many of the countries that have laws that establish suicide as a crime, do not have in place national suicide prevention strategies. This raises the question of whether laws are regarded as substitute strategies for suicide prevention in those countries. The following table lists several countries status on laws and on national suicide prevention strategies:

Nation In Which Suicide Is Criminalised	National Suicide Prevention Strategy
Bahamas	No
Bangladesh	No
Brunei Darussalam	No
Cyprus	No
Guyana - In the process of Decriminalisation	Yes
India – Adopted changes for Decriminalisation	Yes
Kenya	Yes
Lebanon	No
Malawi	No
Myanmar	No
Nigeria	No
Papua New Guinea	No
Qatar	No
Saint Lucia	No
Somalia	No
South Sudan	No
Sudan	No
Tonga	No
Uganda	No
Tanzania	No

This list is not definitive and will be updated by LifeLine International in October 2023. For example, it is worth noting that Ghana and Malaysia have decimalised in the last few months prior to this statement. Please see https://lifeline-intl.com/news/ for the latest information.

A Movement for Change

Lifeline International is launching a global campaign to decriminalise suicide. Lifeline International will work in partnership with interested organisations to coordinate and provide the necessary expertise, resources, and infrastructure to achieve international change for the decriminalisation of suicide in all countries. This includes working with governments and their agencies, civil society organisations, charities and philanthropic foundations, community service associations like Rotary, business leaders and community advocates. Together we seek to mobilise the call for the Decriminalisation of suicide in all countries.

Lifeline International believes that there is an alternative approach for suicide prevention: rather than the use of legislative measures and penalties to deter suicidal behaviour, nations should foster community understanding of suicide as an expression of despair that can and should be responded to with compassion and support to address the factors generating that despair.

This alternative is a more effective way to prevent suicide. It is an approach that addresses every person's right to mental health. It aligns with the advice of experts through the World Health Organization and the International Association for Suicide Prevention. It is practical and achievable. It allows for crisis support services to be easily accessed, widely accepted, and openly promoted in the community, and for national suicide prevention strategies that address the range of personal, social, and cultural factors that may feed thoughts of suicide through health and social programs.

The creation of effective and appropriately resourced national suicide prevention strategies is a critical alternative to laws that criminalise suicide. Lifeline International wants to see national suicide prevention strategies in every country.

As a feature of national suicide prevention strategies, crisis lines are referred to by the WHO as publicly available 'selective' services (World Health Organization 2014). Crisis lines are viewed as cost effective ways for nations to boost their suicide prevention capabilities and the WHO Guide on Establishing a Crisis Line reflects this (World Health Organization 2018). Crisis lines are ideally suited to low-and-middle-income countries where more expensive health and social services are limited. Crisis lines may be regarded as essential service infrastructure for suicide prevention.

Lifeline International believes that crisis lines are vital services. As part of the campaign Lifeline International will work to establish or enhance a suicide prevention crisis line in every country so that all people have access to immediate, quality support during times of personal difficulty and despair. Currently, there are over 2.3 million calls and contacts received by the crisis lines and chat/text services that the Members of Lifeline International operate.

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Contact: Dr Alan Woodward,
Policy Director, Lifeline International

alan.woodward@lifeline-international.com